Claim Verification System

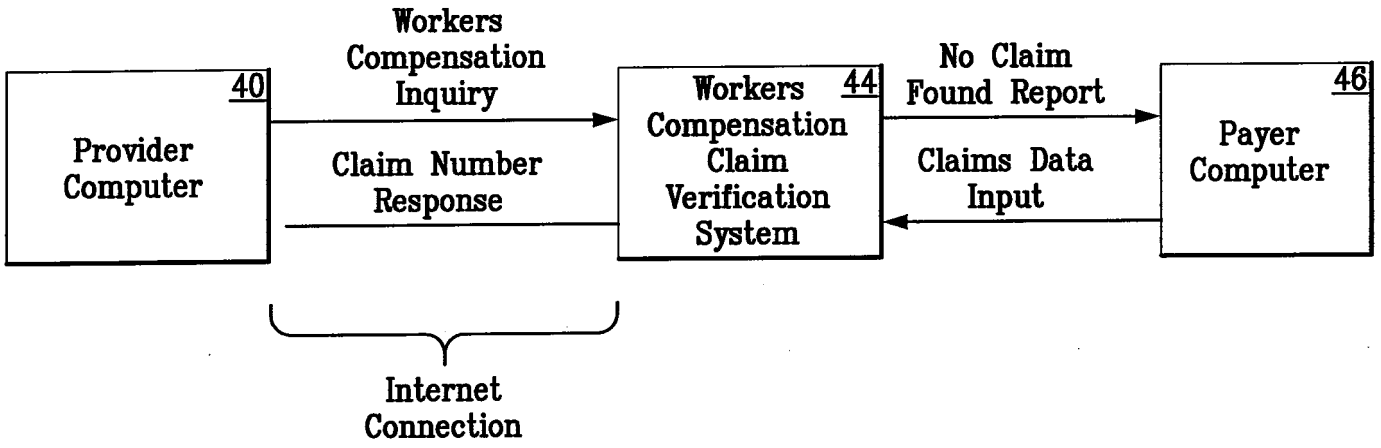


FIG. 1

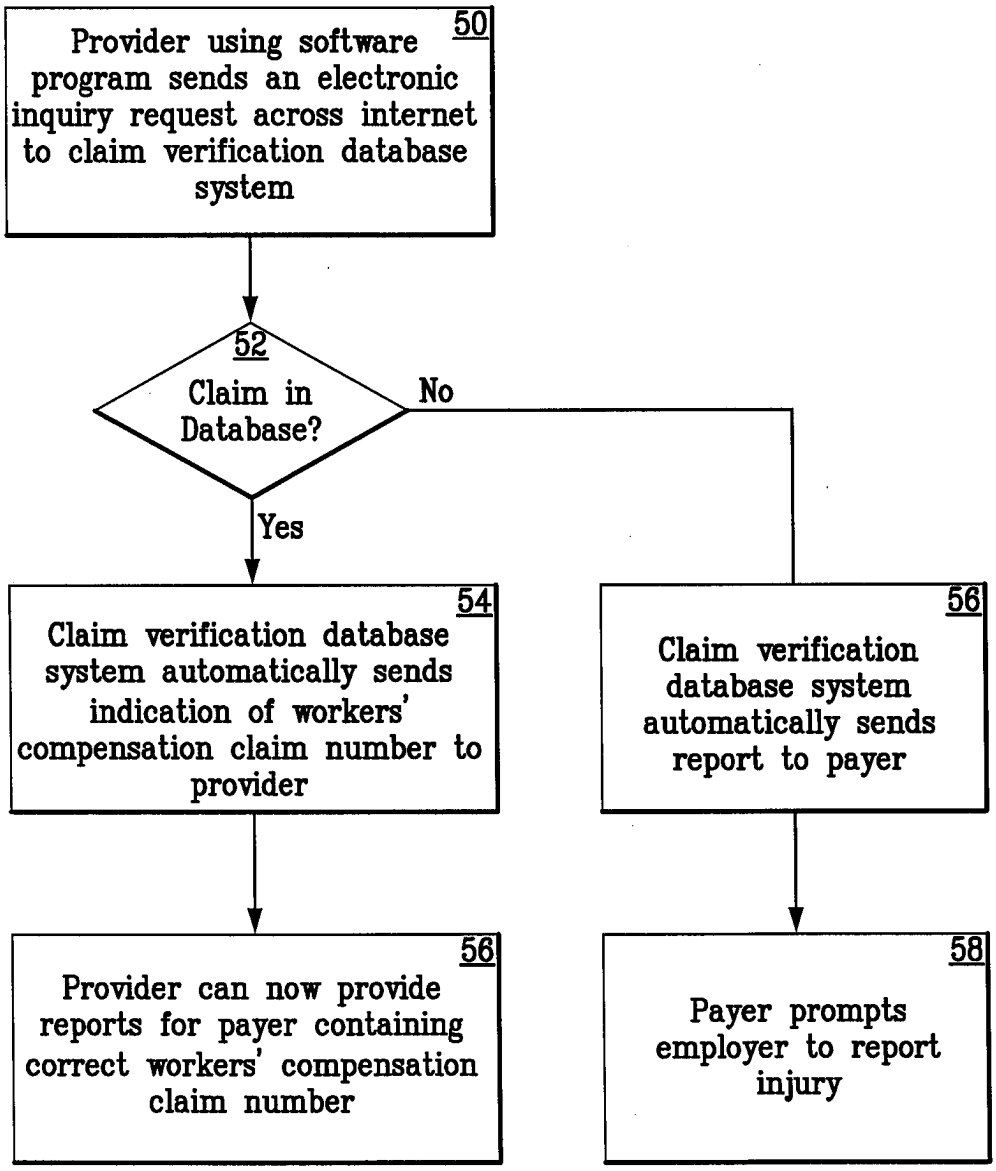
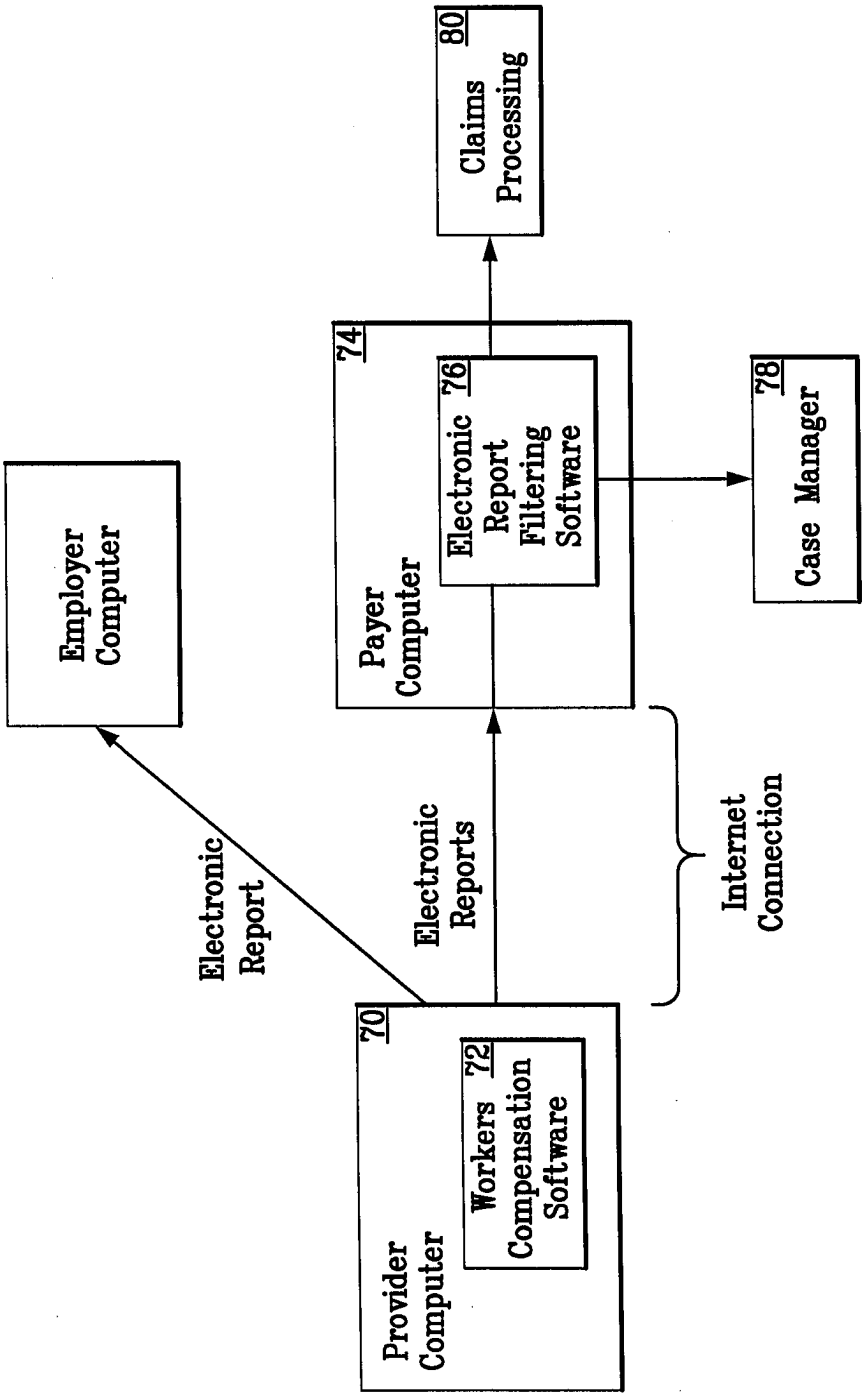

Provider using software program sends an electronic inquiry request across internet to claim verification database system
50
52
Claim in Database?
No
Yes
Claim verification database system automatically sends indication of workers' compensation claim number to provider
54
Claim verification database system automatically sends report to payer
56
Provider can now provide reports for payer containing correct workers' compensation claim number
56
Payer prompts employer to report injury
58

FIG. 2



Worker's Compensation Medical Treatment Reporting

FIG. 3

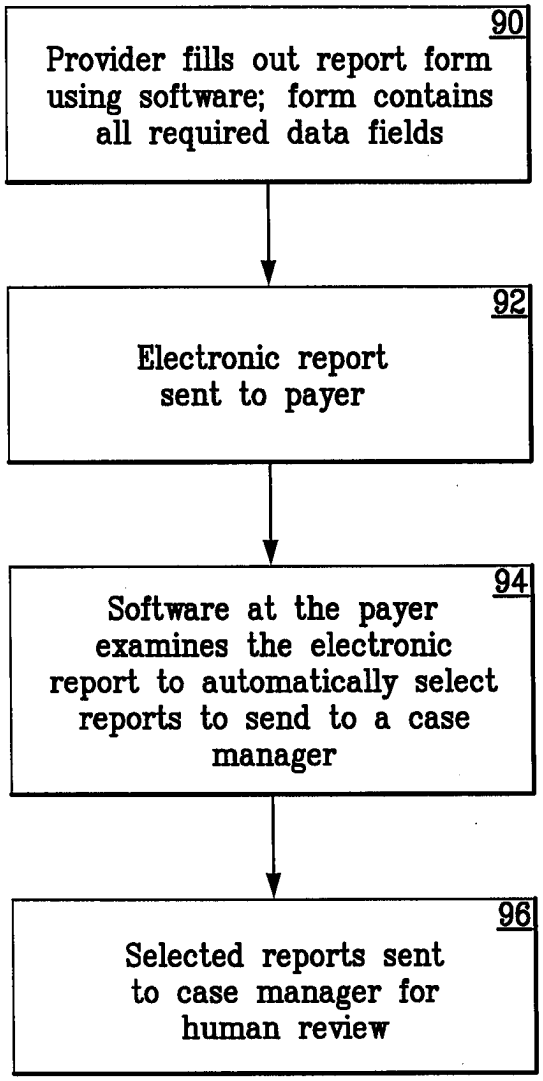

90
Provider fills out report form using software; form contains all required data fields
92
Electronic report sent to payer
94
Software at the payer examines the electronic report to automatically select reports to send to a case manager
96
Selected reports sent to case manager for human review

FIG. 4

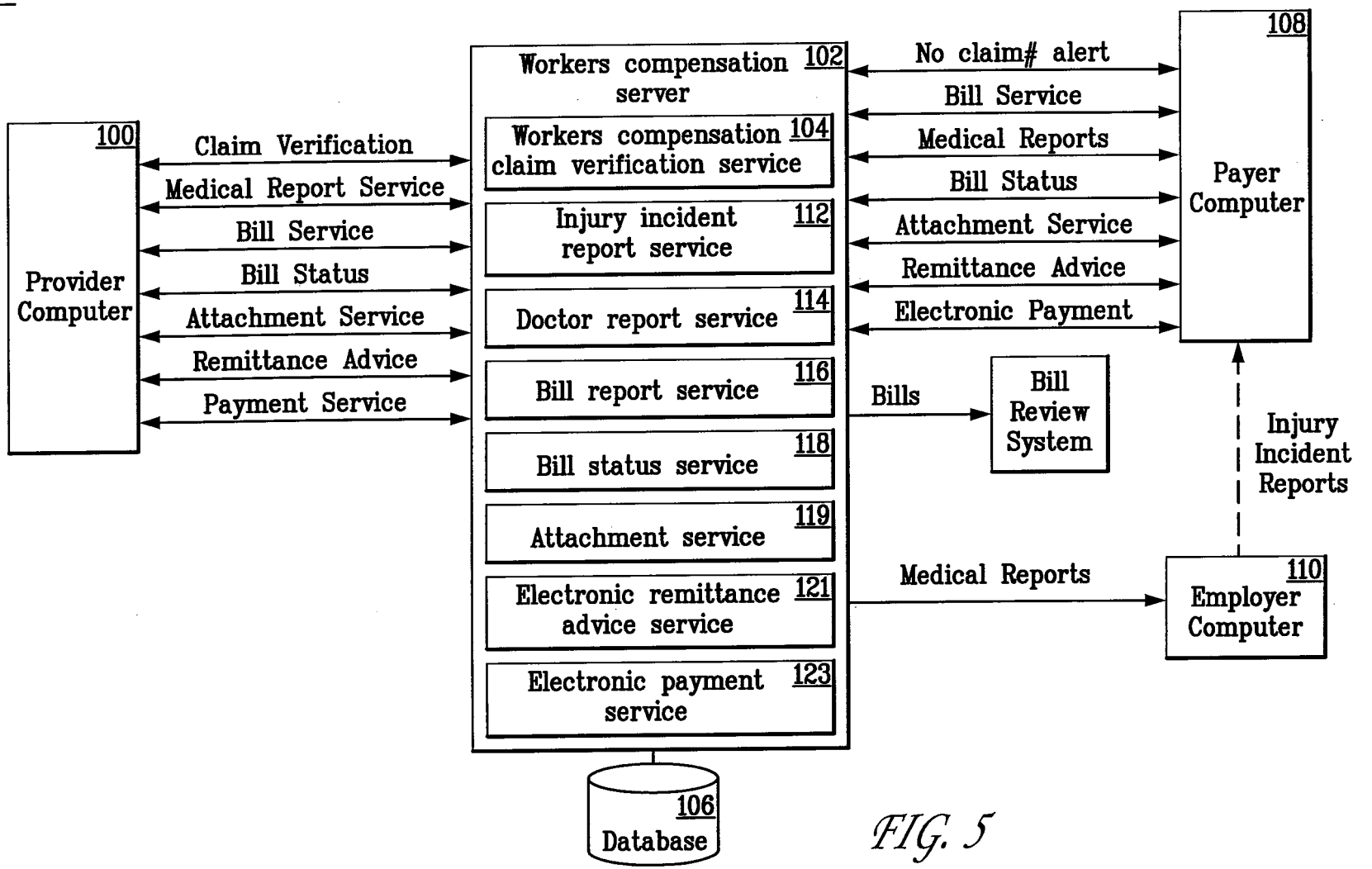

Provider Computer
100
Claim Verification
Medical Report Service
Bill Service
Bill Status
Attachment Service
Remittance Advice
Payment Service
Workers compensation server
102
Workers compensation claim verification service
104
Injury incident report service
112
Doctor report service
114
Bill report service
116
Bill status service
118
Attachment service
119
Electronic remittance advice service
121
Electronic payment service
123
Database
106
No claim# alert
Bill Service
Medical Reports
Bill Status
Attachment Service
Remittance Advice
Electronic Payment
Payer Computer
108
Bills
Bill Review System
Injury Incident Reports
Medical Reports
Employer Computer
110

FIG. 5

First Report (Input Form)

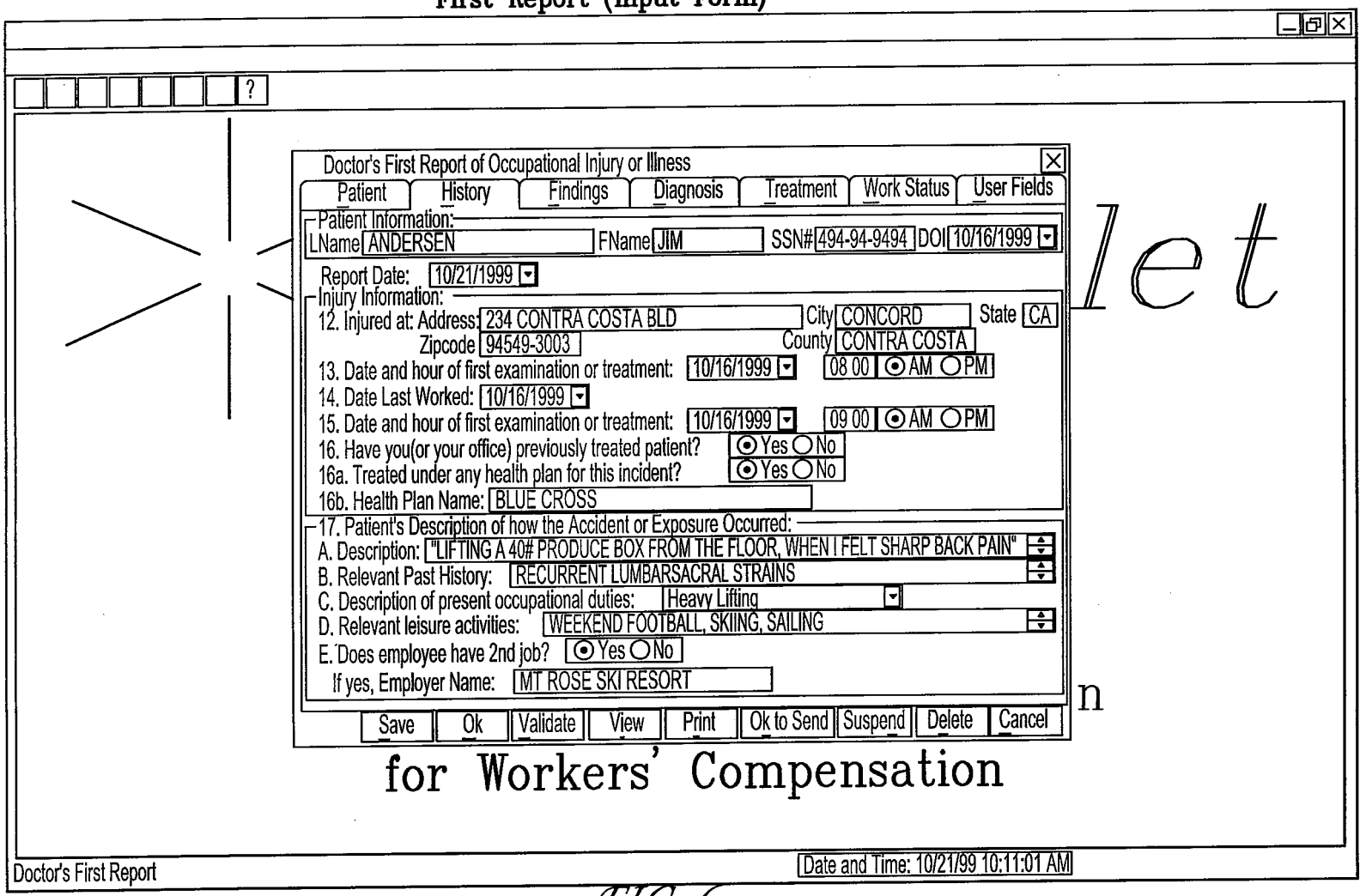


FIG. 6

FIG. 7A

Report Page 1

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

STATE OF CALIFORNIA — File Copy — Page 1 of 2

Form 83012L©1999 — FROM FIRST CASE — Form ID: INS000001000000000Q

1. INSURER NAME AND ADDRESS			1b. Claim #		REPORT DATE
ZENITH, 123 COAST DR., SAN FRANCISCO, CA 945-493393			1b. Claim #		10/17/1999
Telephone Number: 415-339-3939		Fax Number: 415-339-3939			
2. EMPLOYER NAME	3. Address No. and Street	City	State	Zip	Telephone #
LUCKY STORES	234 MARINA WAY	SAN LEANDRO	CA	945-493393	510-499-4949
4. Nature of Business: GROCERY STORE		Policy Number: 499-49-499-4		Fax Number: 510-393-9393	

5. PATIENT NAME (first name, M.I, last name)		6. SEX	7. Date of Birth	Mo	Day	Year
JIM ANDERSON	234 MARINA WAY	☑ Male ☐ Female		10	14	1949

8. Address	City	State	Zip	9. Home Tel #	Work Tel #
1744 RELIEZ VALLEY RD.	LAFAYETTE	CA	945-498888	925-838-3838	925-884-8484

10. Occupation (Specific Job Title)	11a. Social Security #	11a. Date of Hire	11c. Patient Account #
JOURNEYMAN CLERK	494-94-9494	10/25/1994	9-49-49-49-49-4

12. Injured At	City	State	Zip	County
123 CONTRA COSTA RD.	CONCORD	CA	945-493003	CONTRA COSTA

13. Date and hour of injury	Mo	Day	Year	Hour	14. Date Last Worked:	Mo	Day	Year
or onset of illness:	10	17	1999	08:00 AM		10	16	1999
15. Date and hour of first	Mo	Day	Year	Hour	16. Have you (or your office) Previously			
examination or treatment:	10	17	1999	09:00 AM	Treated Patient? ☑ Yes ☐ No			

16a. Treated under any Health Plan for this Incident? ☑ Yes ☐ No 16b. Health Plan Name?: BLUE CROSS

17. PATIENT'S DESCRIPTION OF HOW THE ACCIDENT OR EXPOSURE OCCURRED:
- A. Description: "LIFTING A 40LB PRODUCT UP FROM THE FLOOR, WHEN I FELT SHARP BACK PAIN."
- B. Relevant Past History: RECURRENT LUMBARSACRAL STRAINS
- C. Description of Previous Occupational Duties: Heavy Lifting
- D. Relevant Leisure Activities: WEEKEND FOOTBALL, SKIING, SAILING
- E. Does Employee have 2nd job? ☑ Yes ☐ No If Yes, Employer Name: MT ROSS SKI RESORT

18. SUBJECTIVE COMPLAINTS:
- A. Description: ""SHARP LOW BACK PAIN"
- B. Symptoms:

Body Part	Onset	Quality	Frequency	Severity	Precipitating Activities
Lower Back	Sudden	Sharp	Constant	Moderate	Lifting, Bending, Sitting

19. OBJECTIVE FINDINGS:
- A. Vital Signs:
  HP: 120/80 HT: 5'8" WT: 190 Pulse: 78 Temp: 98.6 Resp: 18 /min
  Allergic to any medications? ☐ Yes ☑ No If Yes, specify:
- B. Focused Physical Exam:
  45 DEGREES LUMBAR FLEXION WITH POSITIVE RIGHT STRAIGHT LEG RAISE AT 60 DEGREES
- C. X-Ray and Laboratory Results:
  NONE
- D. Job Description Reviewed: ☐ Yes ☑ No

20. DIAGNOSIS: (if occupational illness, specify _____ agent used _____ of _____)

A. Description	B. ICD9 Codes
SPRAIN LUMBAR SACRAL	8460

C. Chemical Or Toxic Compounds Involved?
If yes, explain:
D. Other Relevant Diagnosis

FIG. 7B

Report Page 2

... CONTINUED DOCTOR'S FIRST REPORT OF INJURY... ANDERSON, JIM 9-49-49-49-49-4

21. ARE FINDINGS AND DIAGNOSIS CONSISTENT WITH PATIENT'S ACCOUNT OF INJURY OR ONSET OF ILLNESS? ☑ Yes ☐ No
If no, explain:
A. Did work cause or contribute to the injury or illness? ☑ Yes ☐ No ☐ Cannot Determine
If no or cannot determine, explain:
B. Is the patient permanent and stationary? ☐ Yes ☑ No If yes, Date:
C. If no, _____ permanent and stationary date: 11/05/1999
D. Is permanant disability anticipated? ☐ Yes ☑ No

22. IS THERE ANY OTHER CURRENT CONDITION THAT WILL DELAY PATIENT'S RECOVERY? ☑ Yes ☐ No
If yes, explain: Pain surging to other body parts.

23. TREATMENT RENDERED:
A. First Aid ☐ Yes ☑ No
B. Treatment Date: 10/17/1999 — Treatment: OFFICE/OUTPATIENT VISIT, EST — C. Procedure Codes: 99212
D. Instructions to Patient: ERGONOMIC EDUCATION, HEAT AND LOW BACK EXERCISES.
E. Referrals:
F. Disability status: Discharged as _____ with no need for further medical care? ☐ Yes ☑ No
G. If discharged, Discharge Date:

24. IS FURTHER TREATMENT REQUIRED? ☑ Yes ☐ No
A. Medication: VICODIN — B. Physical Therepy: 2 per week for 3 weeks
C. If Surgery, type: — CPT Codes
D. Diagnostic Tests:
E. Estimated Duration of Treatment: 25 days — F. Return Visit Interval: ONE WEEK
G. Recommended Referrals:
H. Treatment Plans, Other:

25. IF HOSPITALIZED AS INPATIENT, Give Hospital Name and Location: Date Adm: Mo Day Yr. Est. Stay: Days

26. WORK STATUS:
A. Is Patient able to Perform Usual Work? ☐ Yes ☑ No
B. If not, date when Patient can return to Regular Work: 10/30/1999
C. If not, date when Patient can return to Modified/Transitional Work: 10/30/1999
D. Restrictions: Specific functional limitations/frequency and weight restrictions based on an 8 hour work day:
Key: (U)nable, (S)eldom=<1%, (O)ccasional=1-33%, (F)requent=34-66%, (C)ontinuous=67-100%

Ability	Limitation	Weight Limit
Repetitive _____	Seldom=<1%	
Lifting from Floor	Unable	
Lifting from Waist	Occasional 1-33%	MAX 15lbs

E. Restrictions Narrative:
F. Is employee likely to become a Qualified Injured Worker? ☐ Yes ☑ No

27. Doctor's Name and Degree: CLIFF L. WILSON, MD — IRS#: 3939334481
Facility Name: FIRST CARE — CA License #: CA2338193483
Address: 123 TAYLOR ST, LAFAYETTE, CA 945468880 — Specialty: OCC MED
FPO Networks: — Doctor's Telephone #: 925-384-8505

<<< DOCTOR'S SIGNATURE ON FILE AT DOCTOR'S OFFICE >>>

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying worker's compensation benefits or payments is guilty of a felony.

Input Form

Claims Verification Service - Microsoft Internet Explorer

e–StellarNet

Claims Verification Service

Enter Patient detail(*All fields are required.*)

Click *here* for batch verification.

Last Name:	SMITH	First Name:	Sue
SSN:	565340665	Date of Injury:	10-24-1999
Employer:	Railway Express	Payer Name:	CSSG

Submit Reset

Back Home Demo Menu

FIG. 8A

Result Page

Claims Verification Service - Microsoft Internet Explorer

e–StellarNet

Claims Verification Service			
Patient details			
Last Name:	SMITH	First Name:	Sue
SSN:	565340665	Date of Injury:	10/24/99
Employer:	Railway Express	Claim Number:	CA334848399
Payer Name:	CSSG	Payer ID:	WC034
Click *here* to perform another lookup.			

Back Home Demo Menu

FIG. 8B

Alert Email

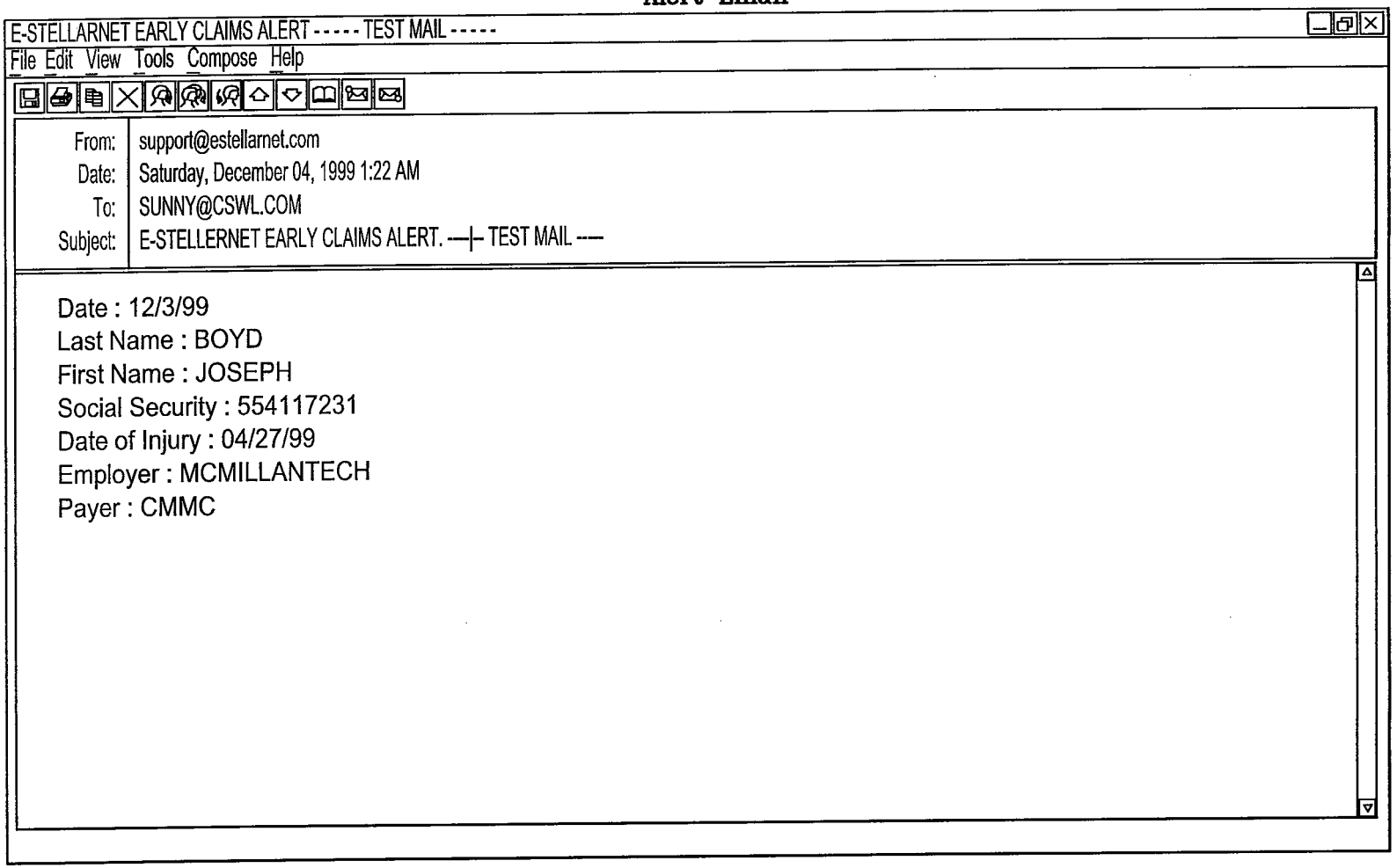


FIG. 8C

Inquiry Email (Form)

e–StellarNet

Provider Payment Status Inquiry Email

An email will be sent to SUNNY@CSWL.COM in the follwoing format

Medical Payment Status

Date: 12/6/99
From: Sunny Paul (sunny@cswl.com)
RE: Employee Name: BOBO NEIL
Employer Name: MARINE WORLD
Claim No. 610061029996195
SSN: 389705260
Date of Injury: 7/22/95
Please advise status on the following invoice:
Date of Service: 10/1/99
Account/Invoice no: 7A9832
Provider Name: DR. KEN ANDERSON
Provider TIN: CA1798321
Date of Invoice: 10/1/99
All Control Number: CMMC10932
Comments: Thank you for your help

Send It | Cancel

Back Home Demo Menu

FIG. 9A

Received Email

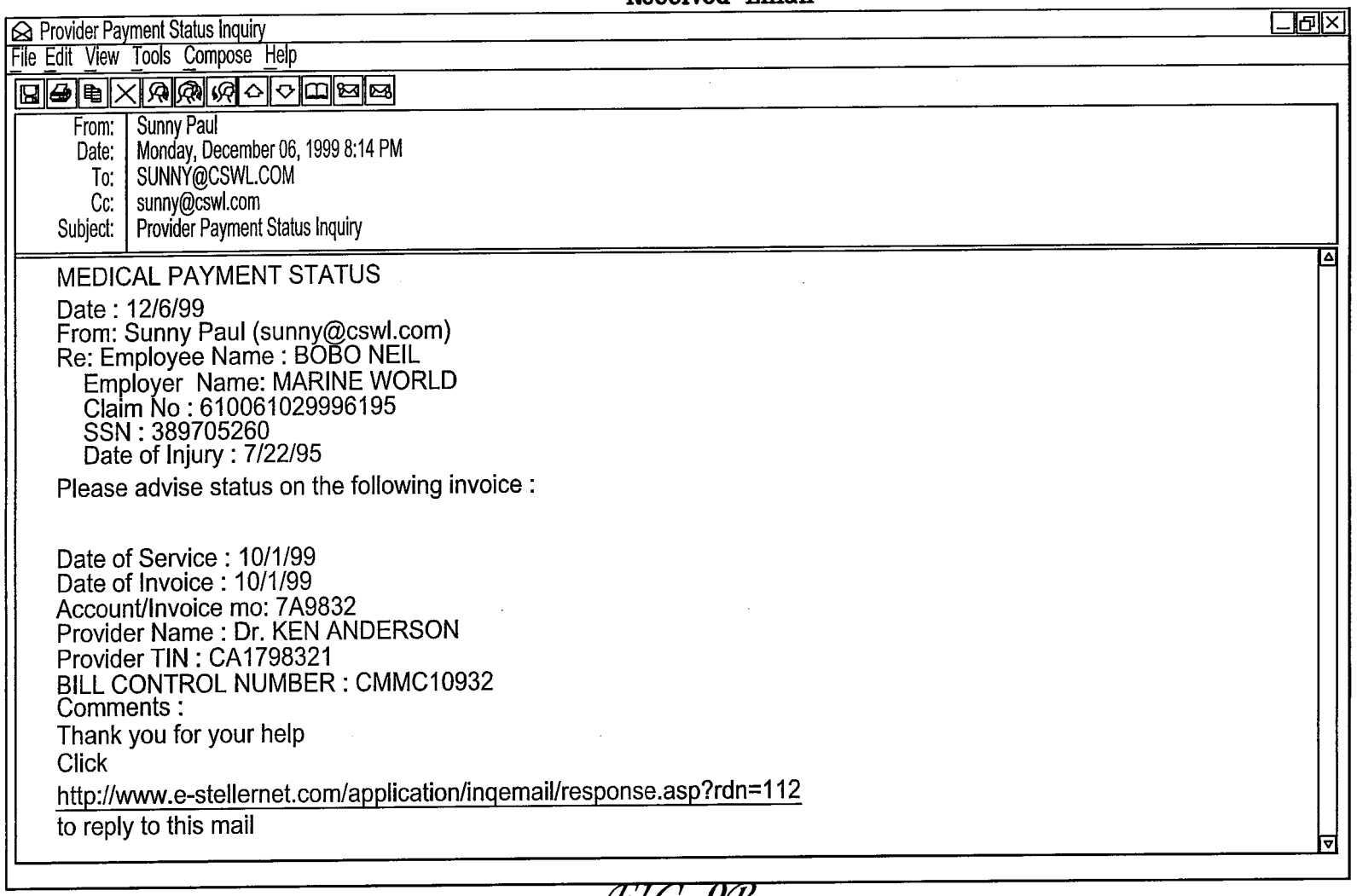


FIG. 9B

Response Form

e–StellarNet

Provider Payment Status Inquiry – Response Email Form

To Medical Facility : sunny@cswi.com

Bill Control No: (BCN): CMMC10932 (For future reference please use the above BCN)

The status of above invoice is:

- (•) Our records indicate payment was released on 10/28/1999
- ( ) Our records indicate payment was paid in accordance with our contract agreement.
- ( ) No further payments are reommended
- ( ) Claim is currently under review for medical necessity
- ( ) Claim is currently under AOE/COE investigation.
- ( ) Claim was denied
- ( ) Necessity for this service is currently under review.
- ( ) No Policyholder Under This Name.
- ( ) We do not have coverage for this employer for this Date of Injury.
- ( ) No Industrial Injury Reported By Employer.
- ( ) Doctor's First Report Needed.
- ( ) Current Medical Report Needed.
- ( ) Itemized Statement Needed.
- ( ) Other

[Next Page] [Reset]

Back Home Demo Menu

FIG. 9C

Response Email

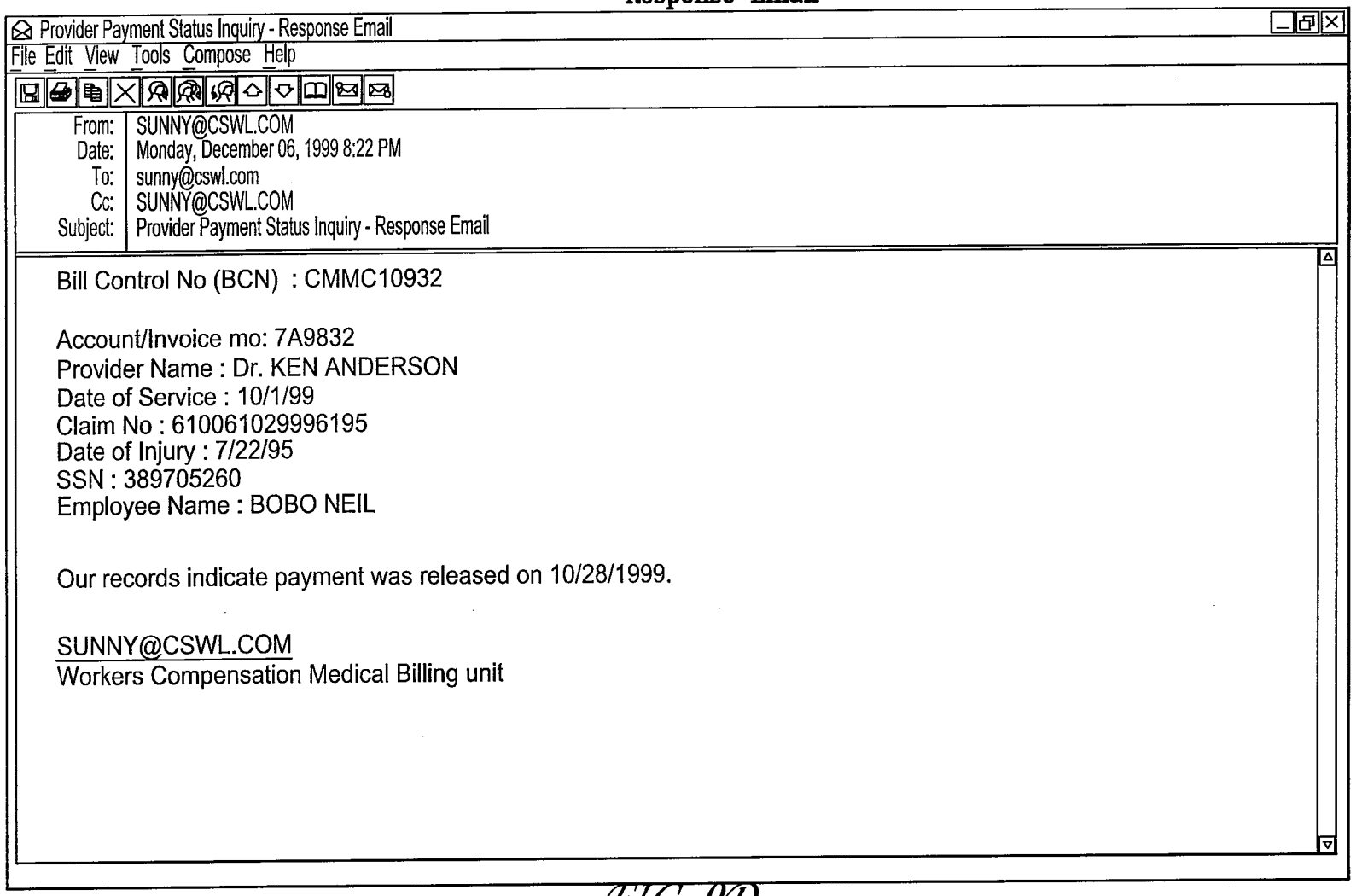


FIG. 9D

Stellar Net Home Page

O

*e-StellarNet

Internet solutions for the workers' compensation community

Home
Registration
Submit Bills
Buyer Progra,m
Information
New Members
Press Releases

The steps to secure Internet processing of claims/bills & workers' compensation (WC) reports are easy as 1, 2, 3. Register today & get control of the Paper Tiger!

	TO DO THIS (using SSL*):	GO HERE	RESUTLTS
1	Register, on-line to submit bills and workers' compensation reports.	☑ Registration	You will receive an email confirming your registration & instructions on how to get started submitting bills
2	After receiving email confirmation & instructions, submit bills from existing medical billing software.	☑ Submit Bills	After bill submission, you will get an acknowledgement within 48 hours for your first submission; within 24 hours thereafter
3	After receiving email confirmation & instructions, download workers' compensation programs & instructions.	☑ Download WC Programs	After you download the WC programs, a key will be sent that permits you to unlock the programs & use them.
*	SSL-Secure Socket Layer encryption		Secure transmission of data.

Click below for additional information:
- ☑ Fees
- ☑ Terms and Conditions
- ☑ Privacy Policy
- ☑ Description of 1500 Data Elements
- ☑ Description of Bill Submission & WC Medical Reporting
- ☑ Payer Information & List of Electronic Payers/Receivers
- ☑ Provider Information
- ☑ Minimum System Configuration
- ☑ Glossary
- ☑ Demonstrations

Other Features:

FIG. 10A

StellarNet On-Line Bill Submission Form

e-StellarNet On-Line Bill Submission

Welcome to StellarNet's on-line bill submission page. Please complete the form:

1. If you are not registered, click here to go to registration page.

2. Registered members, proceed with bill submission:

a. Input your email address in the first box and click on "Report" to double check your membership status. If you are not registered, or if the email address is incorrect, you will get an error message.

b. To submit your bills use the "Browse..." button to select the name and location of the file(s) to submit. You can submit up to 3 files at one time.

c. To submit the bills, click "Upload file(s)" to submit bills.

If you are a first time submitter, you will receive an acknowledgement back within 48 hours after you have submitted your first batch of bills. Thereafter, you will receive the acknowledgement back within 24 hours of submitting your bills.

Please press the TAB key NOT the ENTER key to move down. Use Shift TAB to move up.

Member Upload Password or Email: [ ] Report

Files To Upload:

File 1: [ ] Browse

File 2: [ ] Browse

File 3: [ ] Browse

Upload File(s) Reset Form

Use browser's BACK button to return to previous page.

If you have eany questions...

Call us at 415/882-5700, or Email us at rtwfast@ibm.net

FIG. 10B

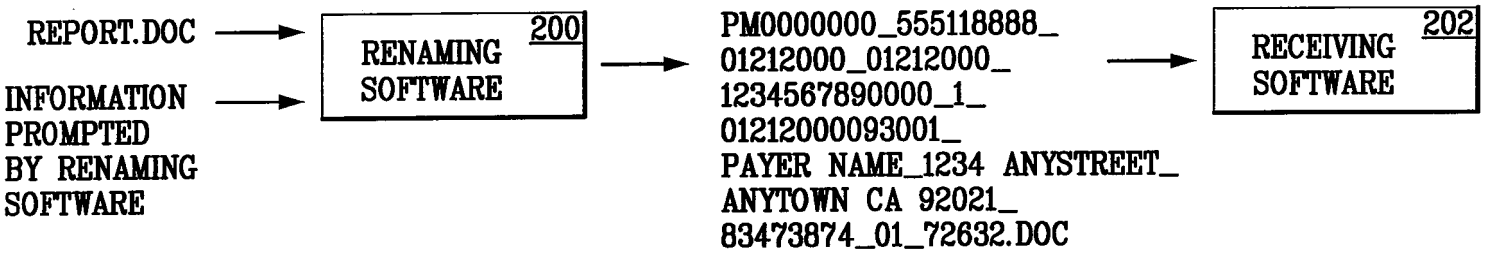

REPORT.DOC
INFORMATION PROMPTED BY RENAMING SOFTWARE
RENAMING SOFTWARE
200
PM0000000_555118888_
01212000_01212000_
1234567890000_1_
01212000093001_
PAYER NAME_1234 ANYSTREET_
ANYTOWN CA 92021_
83473874_01_72632.DOC
RECEIVING SOFTWARE
202

FIG. 11

Field Name	Len	Type	Description / Example
Payer ID	9	Char	Electronic payer ID example: WACA02012. Print and mail payer ID is always PM0000000.
Patient's SSN	9	Char	Example: 123880000
Date of Injury	8	Char	MMDDYYYY Jan 20, 2000 example: 01202000
Date of Service	8	Char	MMDDYYYY Jan 21, 2000 example: 01212000
Type of Service	1	Char	1=Medical Care, 2=Surgery, 3=Consultation, 4=Diagnostic X-ray, 5=Diagnostic Laboratory, 6=Radiation Therapy, 7=Anesthesia, 8=Assistance at Surgery, 9=Other Medical Service, 0=Blood or Packed Red Cells, A=Used DME, F=Ambulatory Surgical Center, H=Hospice, L=Rental Supplies in the Home, M=Alternative Payment for Maintenance Dialysis, N=Kidney Donor, V=Pneumococcal Vaccine, Y= Second Opinion on Elective Surgery, Z=Third Opinion on Elective Surgery.
Provider Tax ID + Sub ID	13	Char	1234567890000 (use 0000 if not using Sub ID)
Submit Date and Time	12	Char	MMDDCCYYHHMMSS Jan 22, 2000 9:30 01 am example: 01222000093001
Payer Name	25	Char	ABC WC PAYER
Payer Address	25	Char	100 MAIN STREET
Payer City State Zip	25	Char	BIG CITY, NY 00030
Claim Number	28	Char	20303200223
Type of Document	2	Char	01=First Report, 02=Supplemental Report, 03=P&S Report, 04=QME, 05=Consult, 06=AME, 07=Entire File, 08=Diagnostic, 09=Chart Notes, 10=Pre-Authorization Request, 11=Referral Request, 12=Disability Status, 13=Surgical, 14=Ambulance, 15=Ancillary, 16=Home Care, 17=Other
ICD9	6	Char	Primary Diagnosis Code, no spaces no period on 5 digit codes.
Period	1	Char	. (also known as dot)
File Type	3	Char	Original file extension, DOC, RTF, TXT, etc.

FIG. 12

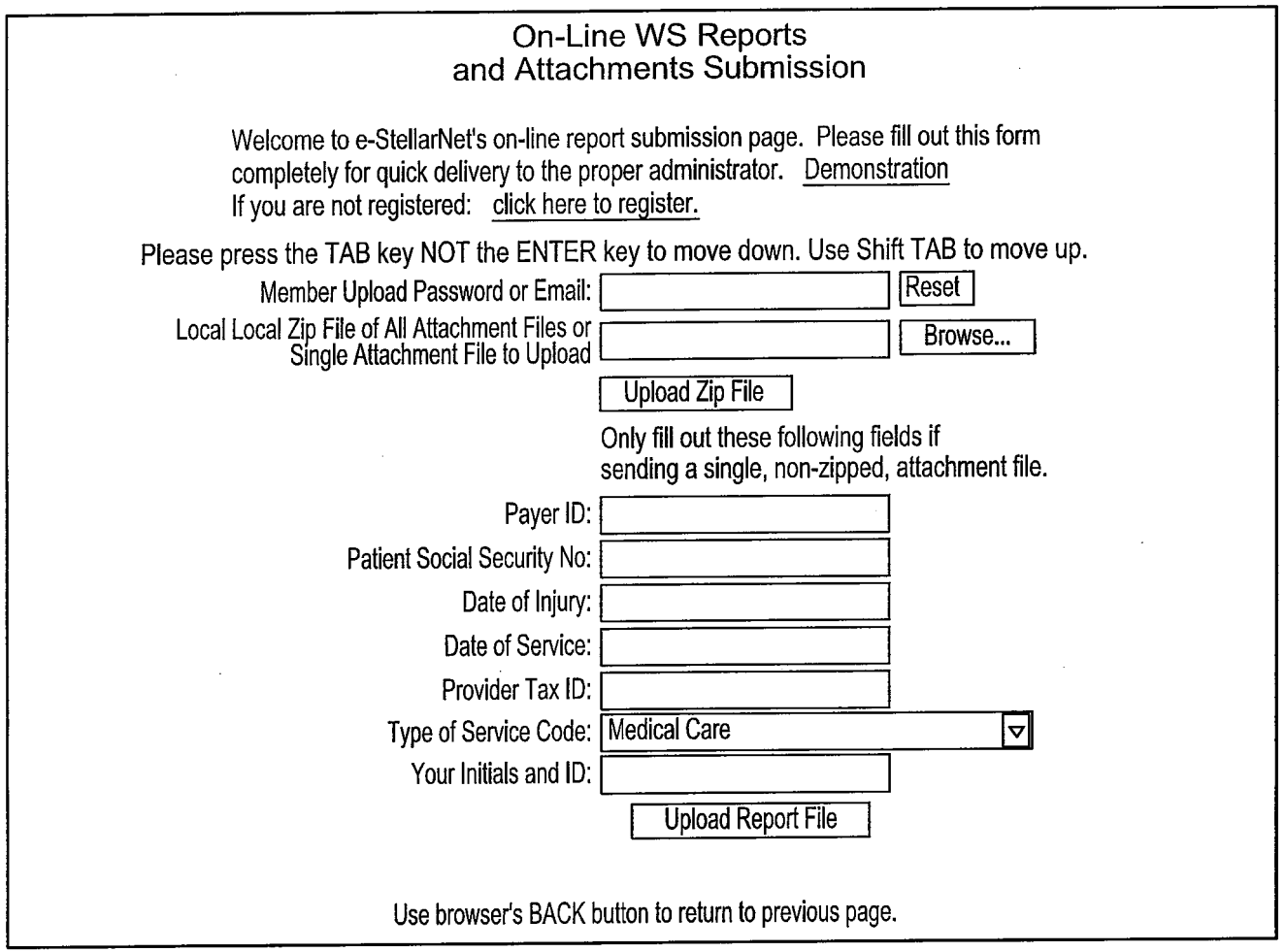

On-Line WS Reports
and Attachments Submission
Welcome to e-StellarNet's on-line report submission page. Please fill out this form completely for quick delivery to the proper administrator. Demonstration
If you are not registered: click here to register.
Please press the TAB key NOT the ENTER key to move down. Use Shift TAB to move up.
Member Upload Password or Email:
Reset
Local Local Zip File of All Attachment Files or Single Attachment File to Upload
Browse...
Upload Zip File
Only fill out these following fields if sending a single, non-zipped, attachment file.
Payer ID:
Patient Social Security No:
Date of Injury:
Date of Service:
Provider Tax ID:
Type of Service Code:
Medical Care
Your Initials and ID:
Upload Report File
Use browser's BACK button to return to previous page.

FIG. 13